DEPARTMENT OF MEDICAID SERVICES
BEHAVIORAL HEALTH TECHNICAL ADVISORY COMMITTEE

****

Capitol Annex
702 Capital Avenue, Room 125
Frankfort, Kentucky

January 8, 2020,
commencing at 2:01 p.m.

Lisa Colston, FCRR, RPR
Federal Certified Realtime Reporter

A T T E N D A N C E

TAC Committee Members:

Sheila Schuster, PhD, Chair
Sarah Kidder
Steve Shannon
Valerie Mudd

DR. SCHUSTER: All right. I think we will go on and get started. Hello.

(Hello. Hi. Happy New Year)

DR. SCHUSTER: I love our behavioral health group, because we are so asocial. As they say when you are on Southwest, if you are not heading toward the Behavioral Health TAC you are on the wrong plane. You all are all on the right plane.

The fourth member of our committee is on her way in. So we will go on and start with introductions. Happy New Year to you all.

There she is. We didn't want to draw attention to you, Sarah. But there you are. There is a sign-in and handouts up here.

Let's start over here, Steve, with you. And we'll make introductions, please.

(Introductions were made, as reflected on the sign-in sheets)

DR. SCHUSTER: Great. All right. There's an agenda up here and minutes for people who just came in and if you would sign in. Thank you all so much for coming.

We do have a quorum. We have Sarah Kidder, who represents NAMI Kentucky. We have Valerie Mudd, who is a consumer, represents Participation Station. Steve Shannon, who represents the community mental health centers, and I represent the mental health coalition. Gayle DiCesare from the Brain Injury Association was unable to make it. And Mike Berry is still recovering a bit, getting his strength back from his heart attack. He's much better, he's home, he's recovering; but he thought that the walk from the garage in the cold would be a little bit strenuous. Although I understand that some of his friends back there volunteered to carry him in, right? He didn't like the idea? He didn't trust you to carry him all the way?

All right. So we do have a quorum. You have the shortest minutes on record.

MS. MUDD: There is one page.

DR. SCHUSTER: One page and no recommendations. I think it is the first time in the six years that we have been doing the Behavioral Health TAC that we did not

have any recommendations from that particular meeting.

So if there's a member of the TAC who would like to make a motion to approve the minutes.

MR. SHANNON: So moved.

DR. SCHUSTER: Steve Shannon.

MS. MUDD: Second.

DR. SCHUSTER: Second Valerie. All those in favor signify by saying aye.

(Aye)

DR. SCHUSTER: All right. Steve, you gave the report at the MAC meeting. Was there anything of note at the MAC meeting?

MR. SHANNON: No. It was a good meeting. It was Commissioner Steckel's last meeting, so that was really the focus, a lot of conversation relating to her participation at the MAC and what happened there. No questions about our report.

DR. SCHUSTER: Well, it is because we didn't have any recommendations, so we didn't have much to report.

MR. SHANNON: Right.

DR. SCHUSTER: I'm going to skip

down the next two items because one of our Humana representatives is getting her tire pumped in Louisville and is on her way here. So we will skip down to changes at the Cabinet.

Stephanie, maybe we can ask you to report on who's in and who's out over there.

MS. BATES: Well, so you all want the scoop, right?

DR. SCHUSTER: Yeah, we want the scoop.

MS. BATES: Right, right. Okay. Well, let me go over here.

Okay. So let me think. You all probably know that Commissioner Steckel left at the Administration change. Lisa Lee will be here on the 16th as the new Commissioner. I've been acting since Commissioner Steckel left. And everybody else is -- we had Genevieve Brown, who was the chief of staff. She left. But you all probably would have never met her. So that's really the Medicaid stuff.

We have a new Director of Program Integrity who started, I don't know, right

after maybe the transition. But I don't know that you all would really -- she came from the AG's office. Michelle Rudovich. So if you have -- that's provider enrollment, too. So if you ever have any issues, she would be in charge of it there. I'm thinking from the Medicaid perspective. That's about it, right?

And then we have Eric Friedlander, who is the Acting Secretary right now. We have Wes Duke, who is the general counsel down there. Carrie Banahan just started Monday as policy adviser in the Secretary's office. And then we have a new legislative liaison, and the name has left me.

DR. SCHUSTER: Kelly Rottman [ph].

MS. BATES: Yes, Kelly Rottman. So that's about it down there. Obviously, admin, Christy left. And the only other person down there that I know of, Jim Messer's out. And then Hans, Hans, who was our other general counsel, they left.

As far as everything else in the Cabinet, DCBS, Eric Clark left. But there's no Acting Commissioner there, so everyone

else is still there. Behavioral health is the same, right? Public Health is still the same, as far as I know. We have a new Inspector General. And I'm sure I'm forgetting something. So...

But that's about it as far as administration that I know of that I can tell the secrets.

DR. SCHUSTER: All right. Thank you very much.

MS. BATES: Thanks.

DR. SCHUSTER: So you've been serving as the Acting Commissioner until Lisa Lee?

MS. BATES: Yes, ma'am.

DR. SCHUSTER: And Lisa was last here at the end of the first Beshear Administration?

MS. BATES: Yes. Yeah. She was here when Governor Bevin came on and then left I think after the 1st of the year.

DR. SCHUSTER: Okay. And we have some more folks that have come in. Do you want to introduce yourself?

MS. EISNER: Nina Eisner,

The Ridge.

MS. BOWLING: Michelle Bowling, The Ridge. Hi, guys.

DR. SCHUSTER: We have got an agenda and stuff up here. Wonderful.

So Eric Friedlander has been in and out of the Cabinet for a long time and I think is somebody who is very familiar with the workings of the Cabinet across all departments, so I think that's a good thing.

Carrie Banahan you will remember was in the Beshear Administration and headed up the very successful KNect. And many of us worked with her on the KNect Advisory Board, I am looking at Julie Paxton, who was a member of that Board. We had a behavioral health subcommittee that was very active that Julie Chaired.

So I'm looking for much more interaction with this new Administration. I think the new Cabinet is much more interfaced with advocate types of people who are receiving services, family members, providers and so forth.

I think David Gray is --

MS. BATES: He's still there.

DR. SCHUSTER: He is still there, right? Yeah. David Gray is the provider, right, the provider rep?

MS. BATES: Uh-huh, basically for the Cabinet.

DR. SCHUSTER: Yeah. And Kelly Rottman is the daughter of Skipper Martin. And for those of you who know Skipper Martin, he was a long-time Democratic lobbyist, was the chief of staff for the Patton Administration and had been a lobbyist for Humana, actually, for a while. So she will know MCOs and some of our issues and things like that. I think that's great.

All right. Very good.

MS. GUNNING: Sheila, do we know what the plan is for Eric Friedlander in the Cabinet? I mean, he's interim. But what does that mean for the long term; do you know?

DR. SCHUSTER: I don't know. Do you know, Stephanie?

MS. BATES: I think they are just still on the search for the Secretary.

That's been what has been communicated so far.

MS. MUDD: He has been good at being interim at a lot of things.

DR. SCHUSTER: Yeah. I thought I read someplace that it was a six-month kind of feel to it, but that could be different than that.

PARTICIPANT: Sheila, it is my understanding that when a Secretary is announced, that he will be Deputy Secretary. So it is not like he is going anywhere.

DR. SCHUSTER: Yeah, yeah.

PARTICIPANT: That's important.

DR. SCHUSTER: Yeah. Thank you. I had heard that.

All right. So an update on Kentucky Health.

MS. BATES: Do you just want me to do the next three?

DR. SCHUSTER: Yeah, yeah. Thank you, Stephanie.

MS. BATES: All right. So as you all know, the Kentucky Health 1115 has been requested to be repealed. The approval --

we are still operating under approval for KY Health, which is the SUD waiver. So that is still going as planned. And we have not heard back from CMS on our request to pull back the other waiver. So that's where we are. So it is kind of just the way it was before, the SUD is still going. And as I know things, you know, I will let you know, Sheila.

DR. SCHUSTER: Okay.

MS. BATES: I'm just going to go down through these, and then you all can ask questions.

The RFP and contract. The contracts that were awarded through this last MCO procurement were cancelled or are in the process of being cancelled or whatever that means. And then as you probably saw through the press conference, the expectation is that a new RFP will be issued Friday, on the 10th. So it's pretty much going to look the same, you know, just little tweaks or whatever here and there. But that's the plan.

So that RFP that has been -- or the contracts that were cancelled were supposed

to start 7/1 of '20. The new ones will start 1/1 of '20. That will be on a benefit year.

MS. EISNER: Not until 1/1?

MS. ADAMS: Sheila, may I ask a question?

DR. SCHUSTER: Yeah. Sure. Absolutely.

MS. ADAMS: So the RFP will still include Kentucky SKY --

MS. BATES: Yes.

MS. ADAMS: -- which is the separate MCO --

MS. BATES: Correct.

MS. ADAMS: -- to handle all DCBS foster children?

MS. BATES: That's right.

MS. EISNER: Is there still going to be an RFP for one entity to manage the foster children?

MS. BATES: Yes. Yeah.

MS. EISNER: Is that what you asked? I can't hear.

MS. BATES: Full disclosure, she said she can't hear. Yes. So for those of you who didn't hear both of those, Kentucky

SKY is the contract for the one MCO for foster care and some others. It will remain.

MS. EISNER: Okay.

MS. BATES: Any other questions on the RFP? I just wanted to ask, because you won't be able to ask after Friday.

MS. EISNER: What is the turn-around in terms of...

MS. BATES: A lot faster.

DR. SCHUSTER: Yeah, a lot faster.

MS. BATES: A lot faster, yeah. I think that the award is for late spring, so if that gives you any idea.

DR. SCHUSTER: So the deadline to respond is, like, a month?

MS. BATES: About a month.

MS. EISNER: Do we have an indication as to how many will be selected?

MS. BATES: No. I mean, I would assume it's the same. So, but, it is going to have to go through the evaluation process. So the same language is going to be in the RFP.

MS. EISNER: No. What I meant was, are we going to have two or five or seven

MCOs?

MS. BATES: Three to five.

MS. EISNER: It will be five?

MS. BATES: Three to five.

MS. EISNER: Three to five, okay.

DR. SCHUSTER: That's what was in the original RFP, right?

MS. BATES: Yes.

DR. SCHUSTER: And you all may or may not know the contract review subcommittee and General Assembly was very unhappy that the RFP's were awarded, contracts were signed. Senator Meredith has been very outspoken in wanting to have fewer MCOs. And he was very unhappy about the results, that it was back to five. So they had unanimously disapproved. Although they say that that doesn't have an impact on what actually happened. But, anyway, they expressed their concern --

MS. BATES: They did.

DR. SCHUSTER: -- about it.

MS. BATES: They did.

DR. SCHUSTER: Okay.

MS. BATES: And then co-pays. I'm

just going to go ahead and give you a quick update on co-pays. The plan is to remove co-pays for fee-for-service altogether and give MCOs back the ability to waive co-pays.

(Yah)

MS. BATES: So that is the plan. It's circling around the Cabinet today and it is going to be filed this month. So...

And I will be honest with you, the way that I wanted to do it was to say no co-pays across the board. But it was going to cost us a lot of money to do that on the MCO side, so that's why we're giving back the ability to waive to the MCOs. And I'm sure it will happen like it did before. But the fee-for-service, all of your fee-for-service will be removed.

MS. MUDD: Yah.

MS. BATES: So any questions on that?

DR. SCHUSTER: And the timing would be? They have to do it in the reg?

MS. BATES: Yes. And, so, we already have the reg written and done. The MCO contracts allow for the waiving of the

co-pays. So whenever an MCO wants to go ahead and do that, make that a policy, they can do that whenever. So...

MS. MUDD: When will that be sent out to members; do you have any idea?

MS. BATES: What sent out to members?

MS. MUDD: To let them know that there are no more co-pays.

MS. BATES: Well, we have to file the reg first. So we're still trying to figure all the communications and all of that out. Obviously, we're going to probably want to do a press release and all of that kind of stuff. So...

Those regs literally were just drafted yesterday.

DR. SCHUSTER: Well, let us know. Because if there is any way that we can help to spread the word. This is the good word. So we would be glad to do that.

MS. BATES: Yes. Absolutely. I will update you on something else that is not on here. It is not really a Medicaid update.

So this is a census year. And one

of the things that we have already in our SPA is the ability to exempt census income for Medicaid eligibility. And so that is already there. And, so, we're operationalizing that.

DR. SCHUSTER: Great.

MS. BATES: So I just wanted to put that out there. We're going to try to come up with some creative ways on portals and all of that stuff. So when we get verbiage, I will send that out to you and the TACs and the MACs to kind of get that out there. So that way if Stephanie Bates is applying for Medicaid, I see something that says, hey, if you had census income, it is exempt, you have got to put that in there, that kind of thing. The same thing for SNAP.

DR. SCHUSTER: We have been asking for that. Because those of you that have been following the census, they are really, really desperate for census workers and particularly people out in communities to reach out and talk to people and get them to fill out the census. And they -- it pays pretty well, it is pretty flexible, it is really a great gig. But we have been worried

about people who were getting some kind of assistance, that that income would boot them out. And, so, we have been asking the Administration for that. So that is great.

MS. BATES: We actually already had it in our SPA and it just was more of a manual, not really known kind of thing. So this is just going to be more -- probably be another press release or with the co-pay, I am not sure.

DR. SCHUSTER: Okay.

MS. BATES: But so that way it is out there.

DR. SCHUSTER: That is fantastic. Kentucky Voices for Health will be glad to circulate that. Yeah, yeah. Thank you.

MS. BATES: Uh-huh. All right. Good.

DR. SCHUSTER: All right. Anything to ask Stephanie, since she's up here?

(No response)

DR. SCHUSTER: All right. Thank you. Nothing but good news, Stephanie. We like that.

Kathy Stevens.

MS. STEVENS: Yes.

DR. SCHUSTER: Hi.

MS. STEVENS: Hi.

DR. SCHUSTER: We're glad that you got here. We understand that you had kind of a tumultuous trip.

MS. STEVENS: I came out of the parking garage to find a tire that was going flat, so thanks for your patience.

DR. SCHUSTER: Yeah. Do you want to come up here to talk to people? I wanted to give Humana a chance to meet all of us. And I'm sorry you were not here for the initial introductions. But this is a group of people who, obviously, are interested in behavioral health from lots of different perspectives, providers, family members, consumers, advocates. And Kathy Stevens is with Humana. And they are replacing, I don't know what the exact word is, CareSource.

MS. STEVENS: We had partnered with CareSource for about six years. And as the Medicaid contracts evolved and the memberships and the needs of the state, we came to a decision to end that partnership as

of 12/31 of this last year, trying to simplify and come up with a model of care that was all at Humana at this point in time and, hopefully, taking out a few layers, making it a little bit easier for folks to communicate back and forth.

But, so, as of 1/1 all behavioral health is in-house at Humana. So what that means for providers, for any run-out of the Beacon issues or anything that was going on there, of course Beacon will be heavily involved and committed to seeing those get to resolution, and then going forward you will just reach out to Humana.

And, so, we're very excited on this part of our adventure. So we're going to give out today, I'm going to give out a few things. I just typed up a simple contact list for everybody that just has some names that you might want to know. Liz Stearman is the Behavioral Health Director. And you will be seeing her a lot in a lot of meetings concerning anything around behavioral health. And we're very happy to have her aboard.

And then also I'm handing out a

provider reference. And there is a little bit of confusion today. So I'm going to ask you guys to make a correction on the second page already, because we couldn't get copies. But you will see that authorizations, prior auth's and utilization management, it has hours down there. It is actually 24 hours a day. So when I hand these out, I'm going to ask you guys to take out your pens and make that correction. And we will be sending that to a mail box.

DR. SCHUSTER: Liz, do you want to help distribute some of those?

MS. STEARMAN: Yes.

DR. SCHUSTER: That would be great.

MS. STEVENS: So one is just a simple sheet, if you want to call some folks that we thought we would...

But with the transition, our goal is to make things easier. So these phone numbers, give them a call. And you are welcome to give me a call, it is not a problem at all.

Any questions that you guys have that we can answer today or anything on your

mind or concerns?

DR. SCHUSTER: Nina.

MS. EISNER: We're having some issues and we're trying to deal with them as a group. But when we're calling for prior authorizations for inpatient stays, we're being told that we'll get a call back within 24 to 48 hours. That's been a problem. Also, for patients who were authorized under Beacon before 12/31, is it correct that Beacon is still managing those cases?

MS. STEVENS: That is absolutely correct. Bridgett is sitting over here with Beacon.

PARTICIPANT: If you have any examples, Nina, I would be happy to bring them back.

MS. EISNER: Good. I would be happy to. And then there is also -- and we actually just kind of aggregated this information yesterday at my hospital. And we're also being told that there's some difficulty in identifying members. And they have had more success when they have been doing authorization calls if they give the

date of birth and the Social and they give clinicals, but some difficulty in identifying who is a member.

MS. STEVENS: Liz has been working a lot of hours on some of these issues that have come to our attention.

MS. EISNER: So these are not new to you all?

MS. STEVENS: Oh, no.

MS. EISNER: Okay.

MS. STEARMAN: Okay. So, absolutely, so we did have to have a bit of a decision made around our authorizations, not only for inpatient, we're talking about inpatient, partial hospitalization, and IOP. All of those will be -- you will be able to get a decision at the time that you call in.

So the decision process is moving from one system to another. And traditionally and historically, Humana has not done behavioral health in-house. We have been with other partners. And, so, it is a new process for our management team. So they are working on sending out notifications around that. You should get that within the

next couple of days. We hope to have that change implemented within, probably, 48 hours. But we have to -- we're going to have to do some re-routing of systems.

So if you are at a point where you're calling in and they are saying they are going to call you back, it is fairly safe to go ahead and assume that those will be approved at that point in time, unless there is some glaring issue. You can always reach out to me at that e-mail address or the contact information that is on there and we will look into those for you.

MS. EISNER: Thank you.

MS. STEVENS: As far as the member identification goes because they -- you know, we have -- I'm sorry.

Because of the change from, you know, they have Humana CareSource IDs, now they are going to have new Humana IDs. All of the members should have gotten a welcome packet with a new medical card late in December. But they may not have that with them. And you guys, as the providers, may still have some old information. So you are

absolutely right, we're asking folks to use date of birth and first and last name is the easiest way for us to identify folks to make sure that -- sometimes we're putting in a CareSource number, our staff on the phones are saying we don't have anyone with that number and they don't look for that number and stuff.

MS. EISNER: Good.

MR. SHANNON: I heard today, I guess the Medicaid website still has CareSource down. So, yeah, I know, I know, I know. So everyone else, check that information. And, you know, availability has the Humana number and they are just -- you know, folks, they may have a card but they are not bringing it with them.

MS. STEARMAN: Sure. And we anticipate that they will not always have that.

MR. SHANNON: And the Medicaid number works.

MS. STEARMAN: The Medicaid number works, yes.

PARTICIPANT: I have a question.

Whenever we call in for authorizations, we're being told that some of our different locations are not registering with you all. Who would I need to contact to kind of get that?

MS. STEARMAN: Sure. So on your contact sheet, is Sheena on there? Okay. Sheena Ashnor or Jesse Settles are the provider folks that you would need to contact. Just to make sure, I would tell you, I know they are still uploading some of the contracts.

PARTICIPANT: So it is not uncommon?

MS. STEARMAN: It is not uncommon. And you can actually ask, ask your staff to just put it in manually at this point in time and say that they got that -- you got that direction at a State meeting. And we are actually giving that direction to our reviewers as well, that if you don't find the provider immediately, then you just do a manual entry for that provider and we can follow-up on the back-end. Because you guys don't -- it should, yeah, not be a payment

issue. But we also don't want that to stop folks from getting services.

MS. STEVENS: And on that one, since it is operational, too, reach out to Jesse. She may be more available.

MS. STEARMAN: Well, we met earlier. So I will follow-up. I can make sure I send a note over to them, too.

MS. STEVENS: What other questions?

PARTICIPANT: So for the authorizations that go through January and they were approved by Beacon, how does that work with the overlapping?

MS. STEVENS: Yeah. So anything that had been previously approved by Beacon we have picked up and moved over to Humana. So if you had an authorization for a certain service up until now, it is still covered by us. If you do have questions and want to double-check or do any kind of checking or if something happens when you file the claim that should not happen, just call that in to us. Anybody on the sheet can help you with that situation.

And then, also, some providers did

get some letters sent out with some of the authorizations that we carried before. Not everybody was able to enter authorizations in January, some folks had a bit of an issue on the Beacon portal where the eligibility ended for that member on 12/31, so they were not able to either request services into January. So we've actually picked up all of those and just went ahead and loaded some extra services in January. And you should have gotten a letter about that. But if you didn't, you can write me an e-mail and I can find it for you and send it over.

DR. SCHUSTER: Any other questions for the good Humana folks?

MS. STEVENS: Thanks for giving us an opportunity to take questions.

DR. SCHUSTER: Well, the timing was real good for you all to have done this.

MS. STEVENS: Yes, yes.

DR. SCHUSTER: And we were anxious to get answers to these questions. So...

All right. Thanks very much.

MS. STEVENS: Thanks, everybody. If anybody needs one of my cards

(indicating).

DR. SCHUSTER: And I will send this out electronically as well. Thanks very much. And the correction that you wanted made, Kathy, was on the second page?

MS. STEVENS: Yes. Thank you.

MS. GUNNING: Twenty-four hours.

DR. SCHUSTER: Where it says "Medical and behavioral health prior authorization and utilization management," it should say "24 hours" in that last column. It shouldn't be limited by hours and days.

MS. STEVENS: Thanks for making my correction for me on your sheets. The correct one will be posted out on the website. We're just getting that corrected so we can get it on the website, so it will be up there as well.

DR. SCHUSTER: Okay.

MS. STEVENS: Thank you.

MS. EISNER: Say it again.

DR. SCHUSTER: Twenty-four. It should be 24 hours.

MS. EISNER: Twenty-four hours.

DR. SCHUSTER: Instead of Monday

through Friday 8 to 8.

MS. EISNER: Okay.

DR. SCHUSTER: Does everybody have that? You have your marking-through pen?

PARTICIPANT: I have one more question for Humana. I'm sorry.

DR. SCHUSTER: Yeah. One more question, Kathy, over here.

PARTICIPANT: Are you guys still in the process of assigning provider reps?

PARTICIPANT: We are in the process of that. We actually have one person, one provider rep for the State hired on the behavioral health side, but we are actually in the process of hiring a second one. But Jesse Settles is your contact until you have an assigned provider rep.

PARTICIPANT: Okay.

PARTICIPANT: Yep.

DR. SCHUSTER: And as you get new people and want to send out that information, that would be helpful, too.

PARTICIPANT: Great. Yeah, we can do that.

MS. STEVENS: We will follow-up and

give you what we handed out today so you will have it available.

DR. SCHUSTER: Yeah. That would be great.

Okay. Any other questions?

(No response)

DR. SCHUSTER: Wonderful. Let's go back up, then, to number five, which has been a source of concern among providers, about how the different MCOs are handling case management. What is your definition of services? What is the preauthorization and for what time period? And what's the limitations on contacts?

And I think we will start at the end of the alphabet and go to WellCare.

PARTICIPANT: I'm sorry. I have got a picture question of who is this person and I was like, I don't know.

DR. SCHUSTER: Do you want to stand up? It might be helpful for people.

PARTICIPANT: Not really. Okay. But I will. Okay. So case management --

DR. SCHUSTER: Show off your new svelte body. That's good.

PARTICIPANT: All right. Case management is authorized, based on medical necessity, and it is authorized based on the clinical information that is given, usually in three-month increments. There's not a limit to the number of contacts other than what is in regulation, which is two face-to-face, one -- is it two face-to-face and one telephonic? Yeah, yeah. For complex. So we follow whatever's in the reg as far as -- but there's no -- you can see the person 18 times. There's no minimum -- there's no maximum number of contacts.

Does that make sense? Like I don't know really what the concern is so I don't know how to address the question. But globally authorization based on medical necessity, the treatment plan is sent in and it is usually in increments of three months.

DR. SCHUSTER: Okay. Any questions, Steve?

MR. SHANNON: And the three months can be renewed. You know what I am hearing from folks, people are getting less case management. And I raise this issue to bring

it up here. And it is not just WellCare's problem. And for me, you know, when I started years ago case management was a core service. And now it has almost become an ancillary service. It is really hard. Everyone gets it, it is not the same, what is the regulations, you are at risk of losing your -- you know, of being homeless versus you're eligible, sometimes that works and sometimes it doesn't.

So what I'm hearing from folks in the field is, it is just not as viable across the system. One county in particular I was at recently, their office was at nine case managers six years ago and they have three today. You know, maybe nine was too many and maybe three is the right number. I don't know. But they have gone from a lot. And I have heard that story repeatedly. So I'm just concerned. It was a core service. It is now kind of being pushed aside, you know, just not happening as much, doing something else.

And this is the venue to discuss things. So that is why the question was

raised.

PARTICIPANT: Well, I think one of the things that we have seen is the dispersement of who is providing case management. It used to be only TNXP. And now case management is everywhere, like every provider, doctor's office.

MR. SHANNON: That doesn't change the people we see necessarily getting less.

PARTICIPANT: Not necessarily. But I'm thinking that that may be part of it.

MR. SHANNON: Well, maybe. But that's not what I have been told.

PARTICIPANT: Okay, okay. Good. I can't speak to generally. We look at medical necessity, it is three-month increments. Like I get a list of people who have been on case management for more than two years. Because I want to see, like, are they still going inpatient, like what is broken? Should they be in ACT? Should they be residential?

MR. SHANNON: Right. I'm just raising that.

PARTICIPANT: Those are things

that --

MR. SHANNON: So I'm hearing a lot of people just getting less case management than they were years -- a similar person was years ago. Folks here probably know that better than I do. But that's the story I get.

PARTICIPANT: Okay.

PARTICIPANT: Well, and, you know, I can speak to the fact that our involuntary commitments are up but our case management numbers are down. Even though we're required to provide case management for anybody coming out of the state hospital, those numbers were low. As a matter of fact, we lost a case management position because we couldn't justify it in Carter County. And Carter County, we just did three 30 day re-admission commitments out of that county. So I don't know if it's a disbursement; you know, I mean that could be it. But we're not seeing the hard-core case management that we thought that we're required to provide according to our contract. Does that make sense?

DR. SCHUSTER: Uh-huh. So, Eric,

do you want to talk about Passport?

PARTICIPANT: Sure. I don't know that I have much of a perspective than WellCare did. We use the Kentucky regulations as our framework. And then we will get medical necessity on an individual basis. We don't have any limitations on overall time frame or number of contacts that it can have during the month. You know, we are looking at, you know, progress through treatment and kind of what the result of their case management is. But, yeah, things similarly to WellCare. We're looking at these on a case-by-case basis. But if there are specific examples, we would be happy...

MR. SHANNON: The same story. I have heard across all MCOs the same message, you know, one county max, three visits.

PARTICIPANT: Is it that your experience is fewer people are getting approved? They are in for less time?

MR. SHANNON: It is both. We own part of this. Because a lot of the centers have changed their process and they only submit people who they know will be approved.

So what happens to the other folks who at one point in life got case management or several people got case management and now they don't get case management, you know, and then is it showing up someplace else?

PARTICIPANT: Yeah.

MR. SHANNON: But, again, for me it was a core service when I started. Regularly we had -- you know, I had one guy who was in the field for 30 years. He said if he could design a system, he would have prescribers and an army of case managers and that would keep people out of hospitals.

MS. GUNNING: He's absolutely right.

MR. SHANNON: And that's not -- you know, it is not working now.

MS. GUNNING: So did we get a question answered, about is it a core service still?

MR. SHANNON: Sure.

MS. GUNNING: I didn't hear an answer.

DR. SCHUSTER: Well, I --

MR. SHANNON: I think it is hard to

ask this group that question. But, again, is that a question for our partners at the Cabinet?

MS. GUNNING: Right.

MR. SHANNON: I don't know.

MS. GUNNING: Because you are absolutely right, it is not happening at the rate that it was.

MR. SHANNON: Yeah. And the IDD and the brain injury world. In the IDD world, you get 15 minutes of respite. You must have case management. Why is mentally ill, there is not the same process. That is not your-all's action, but that is a reality as the group. Fifteen minutes of respite, you must have a case manager.

DR. SCHUSTER: It feels to me like the people on the ground that are working with our folks know that they need a guiding hand more often than not. And, so, case management has always been the guiding hand, just like peer support, which we fought for and fought for to get Medicaid reimbursement for, is that. And it feels a little bit like the MCOs when you talk about, Eric, you know,

moving through the treatment, it feels like, okay, you have -- you know, you've -- you don't -- you shouldn't need as much of that as you have had in the past. And I don't know that that's the way it feels on the ground.

MS. GUNNING: No.

DR. SCHUSTER: And I don't want to put words in your mouth. But I think it is a difference between -- I think the people on the ground, the CMHCs, the family members, want the best for their loved ones and they don't want people to end up in the hospital or in jail or out on the street. And, so, they're looking to do anything they can to build those services around that person to protect them from having that happen.

And it feels like case management -- just like we've always said, the access to the right medication at the right time has always been a piece of that. But it feels like case management is really that support network that really makes the strings that make the safety net. And if you don't have that or if it is hard to get that,

then it feels like we're doling out services and we're going to break the safety net, people are going to fall through the cracks is what is going to happen. So when Marc says, you know, with the Pathways area, we're seeing more involuntary commitments, you have to begin to wonder if there's some correlation here and we're kind of robbing Peter to pay Paul. I don't know.

Allen, I'm going to put you on the spot for a minute. I mean, I wonder if this is a discussion we ought to be having with the Department, in terms of, you know, what do we mean by a core service and what do we mean by, you know, making something available so that people don't fall through the cracks.

PARTICIPANT: Yeah. No, I think it's very important critical services that many people have advocated for for many years and we feel like it is for a particular population of both SMI adults and SUD kids. It is valuable for folks who have Medicaid or are entitled to that service in the state plan. I think if there is a trend it would be interesting to determine where that is by

looking at claims over time and understanding by MCO has there been any significant decline in initial authorizations and durations of our authorizations. Is there a subset of individuals, I believe, who will need this service long-term and chronically? Obviously, there's a process of review that would continue to determine its need. But there is a subset of individuals who many of us know this is a life-saving service that needs to be provided on an ongoing basis. So the question is, how do we identify those?

And then, obviously, medical necessity is the word that, you know, gives leeway to those interpreting medical necessity. So looking specifically at what medical necessity criteria is being applied, are denials being received, are folks appealing those denials, are those denials being upheld. There is a fair amount of data I think we can look at to see if there has been an erosion of the service.

MR. SHANNON: I have concerns about medical necessity. Because the regulation doesn't reference that at all. Right? The

regulation clearly states assistance with housing, vocational, medical, social, educational or other community services or at-risk of out-of-home placement or inpatient mental health treatment. I mean, so that's in section two under eligibility criteria. So it looks like the eligibility criteria has, you know, morphed into something else.

MS. GUNNING: It has.

DR. SCHUSTER: Yeah, Kelly.

MS. GUNNING: I have a case example that I am thinking of and I think Marcie is familiar with it as well. And what it seems like to me has happened is we've evolved into a check box system. Where are they housed? Check. Do they have a therapist? Check. Are they, you know, a client of a CMHC or whatever? Check. And if they meet all of that, then there is no medical necessity. But they are not looking at what is happening to the person. And we can all attest to, especially this one individual I'm thinking of, he's not getting case management anymore. And he really needs it because that is his key to maintenance and sustainability and

being able to do all of those things.

DR. SCHUSTER: To maintain his housing and to make gainful gains.

MS. GUNNING: Right. So I'm wondering, do you just check off these boxes and if they meet that, then there is no medical necessity. You know how some of those forms have follow the arrow thing. I'm wondering if that's maybe what it has evolved into.

MS. MUDD: But if they go by the regs, I mean, the regs...

MS. GUNNING: If they go by the regs, there would be no question.

DR. SCHUSTER: Nina.

MS. EISNER: This is just a little bit different twist. But I will tell you that for The Ridge and for the other hospitals owned by UHS, there's six of us, we have added a considerable amount of case management services to the inpatient world. Because we are -- what we're finding is that we cannot -- we have more adults and we cannot send our patients out without that intensive case management. Otherwise, we're

going to see the re-admissions and we're going to see the adverse events. And you are not going to see those, MCOs are not going to see those, billable's because we have a lump sum daily per diem.

So there is -- I'm just suggesting that at least that population who end up in hospitals are indeed now getting. And I've run this hospital for 17 years. We've never had this much case management services because the life circumstances of patients who come to us would not -- they've changed. And, so, again there -- it may not be a total dearth of these resources, they may in fact be supplemented by some locations that previously didn't do a whole lot of it.

MS. GUNNING: So like what Lori was saying.

MR. SHANNON: CMHCs are doing it and not getting paid. That is another thing. I mean, that's....

PARTICIPANT: Medicare. We have all kinds of Medicare.

MR. SHANNON: Even someone who gets denied, we're supporting them in some way.

It looks like case management.

DR. SCHUSTER: Yeah. Right. People that are payable by Medicare, they are doing case management and nobody is getting paid for that.

So what do we -- oh. And let me give Anthem. Where did they go?

MR. CROWLEY: David Crowley with Anthem. The only difference is, we don't require prior auth's for case management.

DR. SCHUSTER: So do you do it typically in three-month increments, David?

MR. CROWLEY: Provide the service and treatment as medically necessary based on your clinical judgment, bill it.

DR. SCHUSTER: Okay. Thank you. And what about Aetna?

PARTICIPANT: We also do not require prior authorization for case management.

DR. SCHUSTER: Okay.

MS. GUNNING: What about time limits and time frames?

PARTICIPANT: No time limits, no time frames. We perform the service and

submit it.

MS. GUNNING: Thank you.

DR. SCHUSTER: So what is the way -- oh. I'm sorry. Yeah.

MS. STEARMAN: So Humana is requiring prior authorization only for the complex cases. So if you are going to use that modifier for folks with broad behavioral health disorders as well as the -- if you are going to use your HF modifier for substance use disorder so that we can make sure we monitor and perform for the right treatment as well. So also three months, medical necessity, all the rest of that stands. But if you are just doing straight case management, no prior auth is required.

PARTICIPANT: I have a question. How much are you looking at the -- what the CASII and the LOCUS say when you are determining whether the service is needed or not?

DR. SCHUSTER: You are asking an MCO that?

MR. SHANNON: Yeah.

DR. SCHUSTER: The question is:

How much are you looking at the CASII or the LOCUS to determine?

PARTICIPANT: That's what drives the medical necessity.

DR. SCHUSTER: That's what defines the medical necessity?

PARTICIPANT: Correct.

PARTICIPANT: So there's a part that says that it's maintenance on the CASII and the LOCUS, that case management is a maintenance level of care.

DR. SCHUSTER: Well, I don't know. Does maintenance mean it is not a core service? I don't see it that way.

PARTICIPANT: It means that you can have a low level of need and still need case management.

DR. SCHUSTER: You could have a low level of need and still need the service.

MS. SCHIRMER: Without it, it will involve greater intensity.

DR. SCHUSTER: This smacks a little bit of a discussion that we had many years ago that I have repressed with somebody from Medicaid who is no longer there. Kelly

Gunning was in the room. And we were having this discussion about therapeutic rehab programs, PRPs. And this Medicaid person said, "Well, you just keep people in them forever and they don't need that." And we were arguing kind of the case that this is really a chronic, lifelong disorder and it is not going to -- you are not going to be cured of it, you are going to be in recovery from it. And, so, we were having this dialogue. And he was making the case that Medicaid shouldn't pay for it indefinitely. And, so, we said, "Well, what would you do with these folks?" And he said, "Well, they can go to the library." I kid you not.

MS. GUNNING: And then go to jail.

DR. SCHUSTER: Yeah, yeah.

So, and, certainly we're not hearing that from anybody, thank goodness, and the librarians are very happy that we're not recommending it.

But I think it gets at this issue of, are these --

MS. GUNNING: Chronicity.

DR. SCHUSTER: Yeah. And

maintenance. And that's a really good word for it. And our idea of maintenance is that we maintain the person in the community of their choice --

MS. GUNNING: And sustain.

DR. SCHUSTER: -- as much as they can have choice and with a life that they can lead and manage. And what do we need to do that? And if that involves TRP and if that involves targeted case management, then it feels to me like that's a much better investment than waiting until they fall off the cliff or fall into the hole and end up in crisis. And...

MS. GUNNING: It is preventative, really.

DR. SCHUSTER: Yeah, yeah.

MS. BATES: So then why don't we just commit on our end to getting medical necessity criteria from all the MCOs, taking the reg, getting with behavioral health and sitting down and deciding what we're going to ask for, what data we're going to ask for. I think that is the best way to go forward. And we'll just go from there and report back

to you before the next TAC. And if you all have questions also in the interim, because that will take a week or two, shoot them our way if you have got specific questions other than what we've heard today, because we've heard today.

MS. GUNNING: And taking into account about what Nina said, about how much more they are doing on the inpatient level.

MS. BATES: Yeah, yeah. And how do you pull that out of the data and all of that stuff. But we will commit to doing that and kind of reporting back.

DR. SCHUSTER: That would be wonderful, Stephanie. Because I think we do want to look and see whether there really has been a trend for either approving fewer people or approving them for shorter periods of time or something like that.

I also wonder, Nina, because we always talk about the warm hand-off from inpatient out to the community that is so difficult to do and they are getting all of this wonderful case management there, if we can't pick them up when they get out into the

community when they really, really do need it.

MS. EISNER: Sure.

DR. SCHUSTER: You know, then they really do feel like they have been abandoned at the door of the hospital, I'm afraid. And we know, as I'm looking at Diane, that this is a major need for the folks with acquired brain injuries as well. But let's really concentrate on this.

MS. BATES: And if you all have examples where you see that it is a clear case where it has been denied or whatever, shoot them our way so we can see. We will take a look at anything.

DR. SCHUSTER: Okay.

MS. EISNER: Also, is any part of this still about not having a single identified medical necessity criteria that is mandated for use?

MS. BATES: That's why I want to get all of this in and take a look at all of it. Because it wouldn't be unheard of for us to direct the MCOs to use the same criteria. So I just need to get that in.

MS. EISNER: Sure, sure.

DR. SCHUSTER: Yeah, Kathy.

MS. ADAMS: I just wanted to add that I hear this from our members a lot, they have seen, especially over the last year or two, decline in their ability to get approval for TCM services. And, of course, the majority of our members, they deal with adults, too, but a lot of them deal with children, so it is especially difficult.

DR. SCHUSTER: Yeah. I think we ought to do the MCP kids as well.

MS. BATES: Yeah. We will try to split out eligibility, like all the groups, foster kids and not, all of those things.

MS. ADAMS: Another thing that our members brought up recently and it would require a reg change, is that if the child -- if they are a child, they also have to have one contact with the parent or legal guardian once a month. And they are finding that with children, and I say "children," it is probably more teenagers, youth, especially those that are abusing substances, they seek treatment and their parent isn't in the

picture and they might be couch surfing at a friend's house or they may be with grandma but grandma isn't the legal guardian because mom and dad are the problem to begin with. So we're running into a lot of problems in getting it paid for when -- and making that one contact a month. Because it says "legal guardian" rather than some other responsible adult that the child is leaning on at the time.

MS. BATES: Okay.

DR. SCHUSTER: Good point.

PARTICIPANT: And at the risk of me getting shot...

DR. SCHUSTER: She is standing up, so she is a better target.

PARTICIPANT: One of the things that I would like to look at, because we've looked at it in our native, but for those people who are in case management who still are cycling through the hospital. So we talk about, like, case management being that safety net. But how do we look at data to ensure that that safety net actually exists for the people who are getting the service?

Because we see, like, the longer a person is in case management the more likely they are to be inpatient and in crisis. Maybe it is the chronicity of the SMI, which I think is probably there. But is there a way to look at the data to kind of tease that out? If we're just going to ask for the moon, that's been something that I've kind of been interested in seeing over the time, is are we -- how are we creating a recovery and resiliency culture within case management and peer support and how do we improve the outcomes of those services that are improving quality of life? So if anybody has any bright ideas, I would love to really brain storm around that.

DR. SCHUSTER: Yeah. I think those are great questions. And nobody shot you.

PARTICIPANT: That's good.

DR. SCHUSTER: No, I think that's a really important piece as well. Thank you.

PARTICIPANT: That's interesting that you brought that up. Because we recently -- because we don't require prior authorization, you know, we're really looking

into the utilization of that service and its effectiveness. And it is something that we started to look at, is looking at those members who, you know, are involved with case management and then also looking at their inpatient stay. And, unfortunately, just, you know, we're freshly looking at this, we're seeing that there are a lot of inpatient stays for those members. And figuring out, okay, what does that mean exactly? You know, where is that coming from? Are there other needs that are not identified? Are there ways that we can work with, you know, the providers too? Is it a communication barrier, you know, whatever.

DR. SCHUSTER: Right, right.

PARTICIPANT: So how do we support the person so that we're helping them to be healthier and not like -- yeah, I think we're all on the same page.

PARTICIPANT: How do we get there?

PARTICIPANT: And something that we struggle with on the UM side particularly is when we are managing those members that are inpatient, is having difficulty with

communicating with the case manager. So if there are ways that, you know, we can have an improved, an easy way, a consistent way, so while they are inpatient are you, as consultants, can easily contact those case managers and have that fluid flow saying, hey, they are inpatient, they are going to be getting out in a couple of days, can you make sure and see them when they...

You know, and we're seeing that as a barrier on our end when we're trying do that effective discharge planning. So any ideas on how to improve that.

DR. SCHUSTER: Okay. Very good. Kelly, you had a point.

MS. GUNNING: Well, I was just going to say that the devil is in the details of what kind of case management is going on. And I was just going to say, there needs to be improved communication between the case manager and the provider and the MCO. Because every program and every case manager is not created equal. And, I mean, you could be billing for case management. And I know, like in my son's case, he was being billed

for an ACT team and they would -- they drove up in their driveway, rolled down their window, and gave him his check every month. That is what happened. And he ended up in prison and he almost killed us. So, you know, you have to really understand what is happening. And that is so vital and it is so hard to get that information. Because we had no idea. We thought he was under the services of an ACT team, which I know what that means and what it is supposed to look like. But we had no idea what was actually not happening.

DR. SCHUSTER: Right.

MS. MUDD: And I think that happens more likely than not. I know there's --

MS. GUNNING: Just based on our program.

MS. MUDD: Yeah. I mean, I was in -- I was actually in a support group this past weekend and there were two ladies that were angry at the world and they were decompressing. I said, "Have you seen your ACT team? Yeah, but I just turn them away." I think it happens more often than not.

DR. SCHUSTER: So they have one?

MS. GUNNING: Yeah.

DR. SCHUSTER: But they don't really have one?

MS. GUNNING: Yeah. But they never quit billing.

DR. SCHUSTER: Yeah.

MS. EISNER: There are some things that can be so simple, like a hand-off between. I mean, I don't think any of the 42 providers in hospitals that do behavioral health services would object to having part of the discharge plan be a hand-off to the case manager at any and all MCO.

So just setting some expectations universally, which would be pretty simple.

DR. SCHUSTER: Yeah. Over here to VOA.

PARTICIPANT: My question is more for the MCOs. So we have clients in residential treatment and we are calling into the Department and we are obtaining a residential authorization. Is this the responsibility of -- how to coordinate, like for the client, and make sure the client gets

the case management services offered by the MCO, is that something that the UM specialist is supposed to coordinate or is it something that is closed to the system and they have to be managed by residential treatment, we need to reach out to the provider and say, "Hey, we're offering this case management service"? How does that communication need to happen?

MR. CROWLEY: I'm speaking for Anthem. But it is very similar for other MCOs. However you would like to have it happen, as seamless as feasible. We often try to make the referrals from our UM department and discuss those reviews with you or someone else who is covering UM. And they would make those referrals to case management. Or the member can call and request case management.

PARTICIPANT: And I think a lot of times the members don't understand they have that benefit, just based off the population that we may serve. So I know sometimes, and it is like people are in-between that, a case manager will reach out and say, hey, I see you have a member in residential treatment

and we want to set up services, but it doesn't happen on a consistent basis.

So I guess it is understanding how we close as many of those gaps if there are any and make sure the communication is happening between the provider and the --

PARTICIPANT: I think, too, a surefire way is for when the UM calls in for that authorization to say, "We really would like to get a case manager on that." That would be a surefire way.

MS. STEARMAN: The other complicating factor, of course, then, is, you know, can the case manager get ahold of somebody actually on the unit that is not doing UM. That is usually where the rubber meets the road. All of the providers have to interact, you have got to have your clinicians, your social workers that are actually doing social work and therapy, which is what they are supposed to be doing. They don't always have a lot of time to call a case manager or an insurance back. But if we cannot get some of that communication sort of all linked up at the same time, then before

you know it that person is out the door and we're trying to reach them at maybe a number that's not good and, you know, we get lost in the wind kind of thing and we have to wait until they admit again.

So I think a big part of that is getting UM and case management and the actual folks providing the treatment to actually close that communication loop, too. So absolutely if they request case management, then you can start doing those outreach.

DR. SCHUSTER: Does that answer your question?

PARTICIPANT: Yes.

DR. SCHUSTER: Okay. Thank you.

So, Stephanie, you're taking this on?

MS. BATES: Uh-huh. Yeah.

DR. SCHUSTER: Love you.

MS. GUNNING: Yeah, you are amazing.

DR. SCHUSTER: So any input that we have in terms of examples or ideas?

MS. BATES: Yeah.

DR. SCHUSTER: But you will get

with DBH and with the MCOs, look at the medical necessity?

MS. BATES: Yes.

DR. SCHUSTER: We are going to look at both adults and kids?

MS. BATES: All of it.

DR. SCHUSTER: Okay. Wonderful. And it always comes back to communication, right?

MS. BATES: (Moved head up and down).

DR. SCHUSTER: You know, if we were all just talking about the same people. Thank you very much.

Thank you all. That was very helpful.

Pam, what can you tell us about the status of 1915(c) waiver redesign? This is Pam Smith from Medicaid.

MS. SMITH: So public comment officially closed on the 10th of December. And, so, we have been in the process of reviewing all of the public comments we received on Appendices C, I, and G, which included the rate study and the rate changes.

We received about 1,000 comments. So we have went through one round of reviewing the comments. We actually are going through another round tomorrow. I'm hoping that within the next couple of weeks, at the latest by the end of January, that we will have the response to public comments posted. There's a lot of data, a lot of data gathering, too, that's going on looking at that with some of the questions with rates.

CMS did an informal review of the waiver application for us with all appendices except the ones that just went out and we received an informal request for additional information from them. We just received that, so we are responding. It largely was very positive. They are very excited about what we're doing with the waivers.

As far as the regulations, they are in the process right now of being formatted, kind of cleaned up to make sure that they match the -- you know, all of the particulars about how a reg has to be written.

And then we're going to do something new with the regs. Before they are

officially filed and released for public comment, we actually are going to release them to the TACs and our subpanels, at least some of them. I don't know if we will do all of them. But ones in particular that we think that there would be great input, we're going to send those out for kind of a draft review before official public comment.

And, of course, again there will be an official public comment. Once they are filed, we will follow the reg process. Our biggest thing right now we're working on is trainings. And those will roll out as we continue to make changes. The prior authorization process changes at the end of November, along with our Help Desk. And so far it has been received really well. We are getting a lot of interaction. And I think that the case managers have enjoyed being able to get that immediate feedback on our prior authorizations. And then our team in-house, I looked yesterday actually at our stats, and we're maintaining a less than three-day, it is about a two-day turn-around time, on any review that is coming to the

Cabinet to review.

DR. SCHUSTER: Any questions for Pam?

(No response)

DR. SCHUSTER: So this is on the Navigant, we talked about this before, the waivers, the home and community-based waivers, the Michelle P, the two ABI waivers and so forth, right?

MS. SMITH: Uh-huh.

DR. SCHUSTER: And what's the potential next steps for this whole process, Pam?

MS. SMITH: So it will depend on -- the start date will largely depend on when we get to file the regs. Because we can't have -- the regs and the waivers have to go together. So we're still right now targeting a July 1 start date. But in the meantime we are looking at things that we can change.

Patient liability, those changes did go in effect on January 1st. We verified the individuals that patient liability has recalculated. So we have the majority of our individuals have a zero patient liability

now, whereas some of them had significant patient liabilities. I think we only had 10 to 15 people remaining that had a patient liability after those.

MR. SHANNON: How much is that liability for those folks?

MS. SMITH: It's -- it varies. Some of it was, like, $1. It was still really low. We did have a couple of people that ended up with a higher patient liability, but those were few cases.

MR. SHANNON: Apparently, there were people with, you know, $1,000, they were afraid.

MS. SMITH: Yeah. We have had some individuals that were -- you know, that had patient liabilities of 1,700, eighteen, you know, that really --

MR. SHANNON: A month?

MS. SMITH: Yes, a month.

MR. SHANNON: They had to pay that out-of-pocket a month before they got services?

MS. SMITH: Yeah. So this has been a significant change, I think a very

beneficial change.

A couple of other things that we're looking at is if we can change a couple of things with policy prior to, instead of having to wait until July. There's some questions about respite in Michelle P. And then there's some --

MR. SHANNON: Some questions?

MS. SMITH: Yes. Well, it is the last one that is left with. It is tracked on a calendar year versus a plan of care year. And it is hard. So we're looking at something so that we can go ahead and change that and looking at if there's anything with the PDS options, we're looking at those pre-employment costs, what options we have to be able to cover those for individuals.

DR. SCHUSTER: Any questions for Pam on the 1915(c) waivers?

MS. ZIMMERMAN: Can you define "PDS" for us.

PARTICIPANT: Patient-Directed Services.

DR. SCHUSTER: Thank you very much, Pam.

Let's see. We've got good news on contracts and co-pays.

Diane, do you have anything on ABI services and supports?

MS. SCHIRMER: Sure. From the provider perspective, we initiated a lot of the response to the waivers regarding cuts in the brain injury waivers, especially surrounding speech-language services and case management and also cuts that would affect day treatment. Even though they increased vocational work, you can't really get vocational work if you don't have the rehabilitative process prior to that.

From the Brain Injury Association perspective, we have proposed standardized, consistent training for all providers regarding brain injury specific training. Legislatively, we are working to put a brain injury commission or task force in place in this state. We're working on long-term outcomes for brain injury, prevention efforts, and hopefully moving for qualitative audits and providers.

DR. SCHUSTER: Any questions for

Diane? And are you doing the TJ's Bill?

MS. SCHIRMER: Yes, we are.

DR. SCHUSTER: Okay. Do you want to tell people about that?

MS. SCHIRMER: Yeah. TJ's Bill is the bill to really get children 12 and under to wear bike helmets in this state. We've almost gotten it all the way through. But there is usually a block, mostly from the motorcyclists that come and lobby for it not to be put in place. But we really are trying to make a concerted effort to get that bill passed. And if you don't know TJ, he is now an adolescent and fairly vocal. But he was just seven at the time and he actually went off his bike into a curb without a helmet and sustained a severe brain injury. And he and his mom have become super advocates on behalf of getting kids to wear helmets.

DR. SCHUSTER: Yeah. Who is going to carry it for you, Diane?

MS. SCHIRMER: I can't remember right off. I can provide that to you.

DR. SCHUSTER: All right. Let us know. This is the legislative session.

You all might know that. But they are actually in session.

MS. SCHIRMER: Right.

DR. SCHUSTER: The parking lot is full, yeah.

Stephanie, I think I have to call on you on these other things and you may not be able to answer them.

MS. BATES: Okay.

DR. SCHUSTER: We've had this question about the single credentialing entity and what the timeline is. I think there's an RFP.

MS. BATES: And I think it closed.

DR. SCHUSTER: Oh. Okay. It did?

MS. BATES: Yeah. It closed. But there is no timeline because it has to be evaluated. But it is moving. It hasn't been stopped or anything like that. So that's positive.

DR. SCHUSTER: We've been hanging by a thread for a long time.

MS. BATES: I know. But the plan is to still do that.

DR. SCHUSTER: Okay.

MS. BATES: Yeah, for sure.

DR. SCHUSTER: So the RF --

MR. SHANNON: It is the first Happy Chandler Administration.

MS. BATES: Right.

DR. SCHUSTER: So the RFP is closed out, you have got the bids, and now we're in the process of --

MS. BATES: That's right.

DR. SCHUSTER: -- of assigning?

MS. BATES: That's right.

DR. SCHUSTER: Okay. And KI-HIPP.

MS. BATES: I don't really have any update on that. Do you all have a question? I think we're going to make some changes in the reg, based on a meeting we had this last week. But this is not final-final. We haven't submitted anything. But there is a worry that recipients that participate in KI-HIPP, if they lose their employer coverage they will lose their Medicaid or whatever. Anyway, we're going to create something that where the employer has to communicate more. We're just trying to figure out a way to make this a qualifying event, basically, that we

can administratively, you know, obviously operationalize it. But we want to make loss of coverage a qualifying event. And right now it really wasn't like that. This is what I was just looking up, because we just met about this.

And then there was concern about -- this is a hard one. There is concern about, because those that are in KI-HIPP will be in fee-for-service, that a lot of providers refuse to see Medicaid recipients that are in fee-for-service. So we're trying to figure out a way to maybe -- I don't know. It's really hard for us to make providers see Medicaid recipients or police it or whatever that looks like. So any ideas that you all have is great.

MCOs can do it a little bit better because they have actual contracts with providers, so it is a little bit different. And where these are fee-for-service, there is not really a contract. So what we said we would do is go back and look at the actual enrollment process and see what we can do there, and then the regulations. But any

ideas you have there would be helpful. I don't really know how to do that the right way.

DR. SCHUSTER: Yeah. We discussed it a lot in here because we have been concerned about people not understanding what it is.

MS. BATES: Right.

DR. SCHUSTER: And feeling like, oh, if Medicaid is sending me this, then I ought to sign up for it and then really getting caught. So I think there is a group of people for whom it is really a help, but it is a fairly small group of people.

MS. BATES: I agree. And, you know, we're not the best communicator in the world at Medicaid.

DR. SCHUSTER: Did you get that on the record?

MS. BATES: If I could make the MCOs communicate our stuff for us, I would. But, anyway, we're working on it. So any suggestions you have.

DR. SCHUSTER: Okay.

MS. BATES: We just met about this

with Emily and Jason last Friday. And, so, I think we came out with some deliverables that would be helpful. So any suggestions you have.

DR. SCHUSTER: Okay.

MS. BATES: And then...

DR. SCHUSTER: The final one, this is one that we have been talking about for forever, you know, and that is --

MS. BATES: I'm just going to sit down.

DR. SCHUSTER: -- is there any -- you know, we have advocated and advocated and advocated that we go back to having one single formulary, right?

MS. BATES: And that's the way that I think we're headed. I think that's a possibility, more so -- way more on the table than it has been in the past. As you know, we were going to have a carve-out bill. So there is like -- we could have a whole other two-hour discussion about what is going on with PBM and the pharmacy right now. And I really, please, don't want to talk about it.

But, yes, noted. I think that for

us, we are definitely looking at if there's not a carve-out, a single PDL.

DR. SCHUSTER: Oh. That would be so wonderful.

MS. BATES: I am not promising that, but I'm saying we're looking at it. We have to wait and see how. Because if we get carved out, then it doesn't matter, right?

DR. SCHUSTER: It has been so hard for us to advocate and for prescribers who are pressed to know, you know, whose on what, who's on first.

MS. BATES: Right.

DR. SCHUSTER: That would be great.

New recommendations for the MAC. I think we ought to go back to our recommendation that we want a single formulary. We've made it about 19 times before and we ought to make it again.

MS. GUNNING: Until it happens.

DR. SCHUSTER: Until it happens. Yeah, a new Administration.

So can I get a motion from somebody?

MR. SHANNON: So moved.

DR. SCHUSTER: Steve moved.

MS. MUDD: Second.

DR. SCHUSTER: And Valerie seconds, that we ask for a single formulary for all Medicaid.

All those in favor signify by saying "Aye."

(Aye)

DR. SCHUSTER: Okay. Do we have any other recommendations to send forward to Medicaid? We don't have to fight about co-pays anymore.

Yeah, Bart.

MR. BALDWIN: Just that every time the meeting goes this well.

DR. SCHUSTER: Yes. Yeah. We can throw a big welcoming party for Commissioner Lee and her, you know, having our --

MS. GUNNING: Having our people back.

DR. SCHUSTER: -- our BMS and DBH people back and all of this. So we'll wait to make any recommendation around --

MS. MUDD: Is it appropriate to say

thank you for the good stuff?

DR. SCHUSTER: Absolutely. We will definitely do that.

Anything else that we should be making a recommendation about?

MS. ZIMMERMAN: Do you have to vote on that?

DR. SCHUSTER: Yeah, we voted on the single formulary.

MS. ZIMMERMAN: No. The thank you.

DR. SCHUSTER: Oh, the thank you. It goes without saying.

Any other issues or updates that anybody wants to bring forward?

MS. EISNER: I would just like to ask a question.

DR. SCHUSTER: Yeah.

MS. EISNER: You know, the hospital community and I think others are still quite interested in having a single or a consistent medical necessity criteria selection. I don't know if that needs to go to the MAC because it was already in House Bill 69. But it is just hung up in the courts. So just to continue that recommendation I think is

important to at least note.

DR. SCHUSTER: So what happened to it in 69?

MS. EISNER: It recommended -- it mandated a selection of a single medical necessity criteria. And as I understand it, Stephanie you may know, that's now in DOI --

MS. BATES: Right.

MS. EISNER: -- to make that selection. So...

DR. SCHUSTER: Oh. That's right.

MS. GUNNING: Keep it on the radar.

DR. SCHUSTER: Well, do we want to make a recommendation that the forward progress of having a single medical necessity criteria be carried forward or something like that?

MS. EISNER: Just continue to support the --

MR. SHANNON: The response would be, it is tied up in the courts. If I was Medicaid, that would be my response. What can MAC do or Medicaid do right now?

MS. EISNER: Yeah, exactly. Probably can't do anything.

MR. SHANNON: We can say in your comments we had a discussion of this and we are supportive of it. And then it is not a recommendation but it gets reiterated.

MS. EISNER: Exactly.

DR. SCHUSTER: Okay. You know how to make those little comments along the way.

MS. ZIMMERMAN: Did we get a resolution to the ambulance situation? I know that Marc's specific situation has been handled.

DR. SCHUSTER: No, we didn't get a resolution about the ambulance situation. And I think we need to hear from the CHMCs that are having that trouble, because I think they were wanting some specifics about who the carriers were and so forth. And, so, we need to do that.

MR. SHANNON: The reg says if they are not on a gurney, they don't transport, which is a different conversation to have. It is kind of scarey.

DR. SCHUSTER: Do we want to change the reg?

MS. GUNNING: That's what I think.

MS. ZIMMERMAN: That's what I would suggest. But I am not on the TAC. So...

MR. SHANNON: Maybe the recommendation is to review the reg, you know, and see if there are opportunities to make changes. Our friend Stephanie, I'm sure, will help.

PARTICIPANT: The current reg is not friendly to mental health patients.

MS. GUNNING: Right. It is not parity.

MR. SHANNON: It is brain injury.

MS. SCHIRMER: It is brain injury, too.

MS. GUNNING: Anybody who is ambulatory.

MS. ZIMMERMAN: Honestly, yeah. You don't want someone with a missing right foot trying to drive themselves to the hospital.

MR. SHANNON: Personal care. You can get a ride to the hospital but you don't have a ride home.

MS. EISNER: The Hospital Association actually has a task force looking

at transportation challenges to and from hospitals right now. Because, you know, there are so many -- it is such a complex issue; you know, ambulances, yeah, there's definitions by DMS on stretcher versus nonstretcher transport. But there's also realities of the ambulance companies, in terms of how many vehicles they can have out in the county at a time. And, so, there is an emergence of psych safe transport companies that are not ambulances. And what a lot of our hospitals are doing is securing contracts with these people at x amount per mile.

So I think that it's a very complicated issue and it is a challenge probably for every provider in the state. But I just wanted to note that the Hospital Association does have a priority task force on this right now.

MS. GUNNING: Psych safe transport.

DR. SCHUSTER: Yeah. I like that.

MS. GUNNING: Better than a police car. But if they can send them places in a cab...

MS. EISNER: Yeah. Well, and the psych safe transport company has lots of safety measures. They have more than one driver, their vehicles look like police cars with the separation, you know, between the drivers and the back seat and the ability to lock it down. And, so, you know, there's -- yeah, it's complicated.

MS. GUNNING: But it is not a police car.

MS. EISNER: No, it is not. But it looks like it on the inside.

MS. GUNNING: Right.

MS. EISNER: But, yeah. No.

MS. MUDD: Is there a discrepancy if they are not admitted that they will pay or?

MS. EISNER: Well, the issue is, who is paying for it? You know, I am not going to pay for it if somebody is not admitted to the facility and they have just come in. You know, it depends on where they need to go.

MS. GUNNING: Right.

MS. EISNER: So, but, at last

count, the last time I talked to this group, there were 37 of the hospitals out of 127 that had contracted through this group.

DR. SCHUSTER: Oh.

MS. EISNER: I mean, because it makes a difference if you are a med-surg hospital and you have psych patients sitting in your ER, you need to move them, you can't get them transported across county lines to a facility that is more appropriate in that kind of situation, the medical hospital and the receiving facility. Maybe another medical with a psych free-standing would find it beneficial to go ahead and move that patient.

So I just think it is very much a challenge. We're trying to address it in a lot of different ways. So...

DR. SCHUSTER: Will you continue to be a liaison for us --

MS. EISNER: Yes.

DR. SCHUSTER: -- with that group?

MS. EISNER: Yes. And I'm still Legislative Chair for the Hospital Association.

DR. SCHUSTER: That's helpful. Thank you very much.

On the back of your salmon-colored, and I would just point out that the MAC has had to move its meetings in January and in March. So don't come to this room because they won't be here. So I think they ran into a problem with scheduling because of the legislative days and stuff. The same days, same time. But the one is at the Transportation Cabinet in that auditorium over on Mero Street. And then the other is in the great big gray, known as the Cabinet, way back in the boonies, the public health meeting rooms. So just remember. But we are staying right here, folks, right?

(Yes)

DR. SCHUSTER: So we will see you all here in two months, on March the 11th from 2 to 4. And then we will go back to our regular 1 to 3 time. If anybody wants to get alerts about bills having to do with behavioral health, let me know or signup on the sheet that you want to be added to that list, because I'm happy to send you that

information. We have a lot of bills that we're tracking.

And any other business to come before the body, as they say?

(No response)

DR. SCHUSTER: Well, we will adjourn early. Isn't that wonderful? Thank you all so much for coming.

(Meeting concluded at 3:27 p.m.)

* * * * * * * * * * *

C E R T I F I C A T E

I, LISA COLSTON, Federal Certified Realtime Reporter and Registered Professional Reporter, hereby certify that the foregoing record represents the original record of the Hospital Technical Advisory Committee meeting; the record is an accurate and complete recording of the proceeding; and a transcript of this record has been produced and delivered to the Department of Medicaid Services.

Dated this 10th day of February, 2020.

/s/ Lisa Colston

Lisa Colston, FCRR, RPR